TIMOTHY D. LUCEY, DO
1865 Lime Street Suite 103
Fernandina Beach, FL 32034
P: (904) 277-3311 F: (904) 277-3343

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

I am completing this form to allow the use/disclosure of protected health information about

(Printed Name) _____ (Date of Birth) _____

I authorize the following Doctor or organization to release my medical records:

_____

to obtain (use) _____ to disclose _____ both use and disclose_____
the following information:

Check all that apply:

Complete Copy of Medical Record _____

ER Records _____ Outpatient Records _____

MRI/CT Reports _____

Laboratory Studies (blood work) _____

EMG, NCS, EEG _____

Psychological/Psychiatric Evaluations, Reports, Assessments, Progress Notes _____

Physical Therapy Notes or Chiropractic Care _____

HIV-related and drug/alcohol information contained in records _____

Dates of Care: From _____/_____/_____ to _____/_____/_____

And from _____/_____/_____ to _____/_____/_____

And from _____/_____/_____ to _____/_____/_____

Other (specify) _____

Please Fax or Mail my records to this person or Organization:

Timothy Lucey, DO, PLLC
1865 Lime Street
Suite 103
Fernandina Beach, Florida 32034
Phone: 904-277-3311
Fax: 904-277-3343

This information will be used/disclosed for the following purposes: Evaluation and Treatment

I understand and agree that this Authorization will be valid and in effect until: (Date) _____.
I understand that after this date or event, this information cannot be used or released to the person or organization unless I sign a new Authorization such as this one. I understand that I may revoke or cancel this Authorization at any time by sending a letter to the Privacy Officer of the Organization listed above, which is to supply this information. If I do this, it will prevent any releases after the date it is received, but cannot change the fact that some information may have been sent or shared prior to that date. I understand that if the person or organization that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information above may be pre-disclosed and no longer protected by those regulations. I affirm that everything in this form I did not understand has been explained to me and that I understand this form completely,

Patient Signature: _____ **Date**: _____

Printed Name of Personal Representative: _____

Relationship to Patient: _____

I acknowledge that I received a copy of this completed form (initials) _____